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ABSTRACT

Native Americans constitute a significant population that is growing and has great need for mental health and counseling services. Social problems in Native communities include high rates of alcoholism, alcohol-related deaths, drug use, youth suicide, and sexually transmitted diseases. Despite their mental health needs, Native Americans are seriously underserved by the mental health professions, particularly psychology. Given the shortage of Native psychologists and counselors, non-Native counselors will be serving Native Americans and should have a basic understanding of their history, present status, and general ideas about traditional healing. However, the Native American population is extremely varied. A major variable is an individual's level of traditionalism versus acculturation to mainstream American society. Some Native ideas about traditional healing include the importance of a harmonious relationship with all of creation, emphasis on spirituality, and a holistic approach that mobilizes family and community to support the individual. Suggested approaches and strategies include providing a counseling orientation at the first session that explains the mutual responsibilities of counselor and client, maintaining trustworthiness, learning about tribal background, avoiding insight-oriented therapies, focusing on behaviors rather than emotional states, being aware of subtle verbal and nonverbal components of communication, visiting the client's home, collaborating with traditional healers, and using self-help and mutual support groups. (Contains 35 references.) (SV)

NATIVE AMERICAN INDIANS AND THE COUNSELING PROCESS:

CULTURE, ADAPTATION, AND STYLE

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INTRODUCTION

Focusing on counseling Native Americans is due to this writer's previous experience on the Menominee Indian Reservation in Wisconsin as a VISTA volunteer. Duties included counseling and tutoring teen-aged boys and girls, providing social services through the Community Action Program, directing an activities and recreation center, and working with high school seniors in scholastic and vocational programs. As a young man, twenty-three, and recently removed from an urban college campus, the shift to a rural locale populated with a markedly different race of people proved both enlightening and frustrating. Armed with boundless enthusiasm, and more than a little naivete, this writer was to learn over the next twelve months that many of his preconceived notions about Native American society were the result of limited education and misinformation, factors that were only then, in the late 1960's, beginning to be rectified in our country through an emerging Native American pride and its people's demand for restitution from the United States government.

Intensive study and six weeks of training offered a measure of preparation for the term of service, but it was only through the harsh lessons of experience that a better understanding was realized of the ways of the Menominees with whom this writer lived and worked. While understanding it would not be possible to be accepted completely by the community, in retrospect, some measure of respect for trying to learn from these people rather than striving to change them, was achieved.

PREVALENCE OF SOCIAL PROBLEMS

All of the societal problems which existed on the Menominee Reservation are still pervasive there and in every Native American community throughout this nation. Alcoholism, drug use, suicide among the young, and crime continue to be the prevalent issues, and they are occurring at levels equal to or greater than other racial groups in the United States (LaFromboise, 1988; May, 1987). Native Americans are among the poorest and hardest hit by unemployment (Barter & Barter, 1974), experience a significantly higher incidence of tuberculosis and cirrhosis of the liver (e.g., May & Dizmang, 1974), alcohol and tobacco abuse (Lewis, 1982), depression and infant mortality (Westermeyer, 1974). They are at greater risk of death by homicide, suicide, and preventable accidents (Barter & Barter, 1974), and their delinquency and arrest rates are among the highest of all ethnic groups (La Fromboise, 1988).

Death by suicide has been a growing phenomenon among teenage and young adult Native American males for the last two decades, as has the tendency for such suicides to occur in clusters through the process of imitation (Bechtold, 1988). While suicide among Native American populations has correlated with low social status in white society it has also been viewed as an honorable reunion with one's ancestors. May (1987) identified a number of factors characterizing tribes with high suicide rates; these include failure to adhere to traditional ways of living, to traditional religion, to clans and societies, and the resulting chaotic family structure and adult alcoholism. Long(1986) cited a mix of transcultural pressures and prejudices creating a no-win situation for Indian youth. Other risk factors for suicide were: a focus on internalizing feelings and being in control, hopelessness due to reservation life, and a lack of anonymity. Oftentimes these youth at risk had lived in a chronic state of dysphoria before they acted in an openly self-destructive way. This condition could usually be traced back to early adolescence. The core of the emotional disturbance seemed to be a cultural identity conflict which lacked a goal directedness in life (May, 1987).

Alcoholism and alcohol-related deaths continue to account for a disproportionate share of the social problems of Native Americans. In a two-year study by the Indian Health Service on the Cheyenne River Sioux Indian Reservation in South Dakota, 53% of all deaths were from unnatural causes--motor vehicle accidents, hypothermia, suicides, and drowning. Almost all were alcohol-related, and the average age of death of this group was 24 years (Prager & Lujan, 1993). Native Americans have turned to alcohol in such large numbers because of despair. Their culture has been forcibly and cruelly suppressed for decades by the white man, and no culture has risen to take its place. Economic and educational opportunities on the reservation remain minimal. Children are shuttled between the anonymity of a government boarding school and the social pathology of alcoholic households (French, 1989). Exercising tribal sovereignty and passing laws aimed at reducing problem drinking behaviors has had a positive effect on the prevention of alcohol abuse, but tribal regulation alone cannot solve all the problems of alcohol abuse because these problems are multifaceted. (Prager & Lujan, 1993) observed that solutions must be comprehensive and must address the root causes, including individual and institutional racism, cultural and physical genocide, unemployment and underemployment, and a lack of quality educational opportunities. Additionally, negative stereotyping and misperceptions about American Indians and the United States government's paternalistic policies have continued to undermine various aspects of the federal government's relationship with American Indian tribes.

In 1992, a Senate Indian Affairs Committee approved an Indian Health Services bill authorizing cuts in existing alcohol and substance abuse programs, after concluding that the current programs were inadequate or never implemented. The Committee proposed that a new system of programs needed to be developed, that professionals from the regions where they were needed be hired, and that funding for medically necessary travel be provided (Thomas, 1992).

Demographic data regarding AIDS cases concluded that Native Americans, while having the lowest cumulative total number of cases, had the highest relative increase in cases compared with other racial and ethnic groups. Native Americans had high rates of sexually transmitted disease--more than

twice those for other ethnic groups--and extremely high rates of intravenous drug use which could facilitate disease HIV transmission (Metler, Conway, & Stehr-Green, 1991).

Of this country's ethnic minorities, Native Americans are perhaps the most in need of effective social, health, and mental services. The causes of their problems are a debated issue. However, core reasons often cited relate to the acculturation and deculturation stressors wrought by by the dominant European-American culture (French, 1989). According to this position, the destruction of traditional cultural values, practices, and means of support (deculturation), and the failure of the dominant culture to force full assimilation/acculturation have left most Native Americans caught between conflicting cultures. As a result, many find themselves in a socially and economically untenable position. The resulting personal and interpersonal stressors then precipitate diverse health and mental health problems.

Despite the significance of their mental health needs, Native Americans are seriously under-serviced by the mental health professions in general, and by psychology in particular. Indeed, Matheson (1986) has asserted that they are the most neglected ethnic group by the mental health field, and LaFromboise (1988) has noted that the number of Native American psychologists in proportion to the native population is about one-fourth that available to the general population.

A review of the literature on Native American mental health supports Trimble's (1990) contention that until the 1970's, it was common for psychologists to assume that the study of Native American was the purview of anthropology. Although this is changing, relatively little of the accumulating literature addresses the counseling process, and research-based reports are minimal. Thus, articles of direct relevance to Native Americans in therapy remain scarce. Indeed, the results of a recent computer search by Saks-Berman (1989) revealed that only 38 articles had been published on psychotherapy with Native Americans during a twenty-year period.

In summary, the mental health needs of Native Americans are at least as great as that of any other ethnic group, and yet they are among the most underserved by the professions. That Native Americans are this country's fastest growing ethnic group suggests that this need-service gap will only worsen

unless corrective actions are taken. Because so few Native American psychologists exist, and since the number of Native Americans successfully pursuing higher education is declining in relation to non-natives (Kidwell, 1991), it follows that this task will largely fall on non-natives in the foreseeable future. Since more than half of Native Americans live in urban areas, and most large cities have at least 10,000 Native American residents (Stock, 1987), most school and mental health counselors will, at some time, have the opportunity to provide counseling services to Native Americans.

COUNSELING THE NATIVE AMERICAN CLIENT

The Native American population is extremely varied, and it is impossible to make general recommendations regarding counseling that apply to all Native Americans. A major variable is the degree of traditionalism of an individual versus the degree of acculturation to mainstream American society. The continuum stretches from the very traditional individual born and reared on a reservation, who speaks the tribal language, to the Native American raised in a city who speaks only English and may feel little identification with a tribe (Dillard, 1983).

Given the diversity of the Native American population, the counselor must be careful to avoid stereotyping Native Americans based on general assuptions. Lloyd (1987) pointed out that differences within cultural groups can be greater than differences between such groups and cautioned that studying generalities about a particular culture can blind a therapist to the uniqueness of the client.

One ancient Native American idea about health is that health results from having a harmonious relationship with nature. All creation is seen as a living, seamless whole (Trimble, 1990). Nature, being whole, cannot be separated artificially into physical, mental, or social parts. Rather, all of life is seen as a spiritual process. Individuals are considered relatively insignificant compared to the tribe, and an individual's problems are considered a problem of the group

(Attneave, 1985). Traditional Native American healers do not specialize in physical as opposed to mental or emotional problems, for they believe there is no such thing as a problem in only one of these areas.

From a traditional perspective, the term mental health is a misnomer, since it implies that a mental aspect of a person can be separated from the rest of the person. Except for family therapists, non-Native American service providers tend to focus on individual mental health and locate psychological problems within the individual. From a traditional point of view, the individual exhibits a problem that is assumed to be rooted in the community (Spector, 1985). It would be very rare for a traditional healer to treat an individual in isolation; the extended family, friends, and neighbors are mobilized to support the individual and get him or her integretated into the social life of the group (Lewis & Ho, 1989). Typically, the healing ceremonies occur in the client's usual surroundings rather than in an unfamiliar place.

With regard to cross-cultural counseling, the expectations of both the client and the counselor can have a large impact on its chances of success. The potential mismatch between the expectations of Native American clients and non-Native American counselors may explain why Native American clients often drop out of therapy. Sue & Sue (1977) observed in one study that over 50% of Native American clients who went to mental health centers failed to return after the first interview, compared to a 30% drop-out rate among other groups. Therefore, counselors must strive to make the first interview with a Native American client therapeutic rather than use it simply to collect information from the client and make a diagnosis of the client's problem. Youngman and Sadongei (1974) concluded that many Native American clients simply did not know what was expected of them, and that the notion of what constituted good client behavior may never have occurred to them. The client who has not been given a good orientation to counseling and made to feel hopeful in the first session will in all likelihood not return for a second session.

The counselor can improve the odds of having a good first session by preparing for it in advance. The general Native American model of healing previously discussed can be used to get some clues concerning how Native American clients might regard counseling. For example, it could be

assumed that Native American clients might expect the counselor to diagnose their problem without prying too deeply into their personal life or asking many intimate questions (Edwards & Edwards, 1989). It would also be reasonable to expect that family members would be invloved in the counseling and improvement would occur rather quickly. Even a less traditional client might have a tendency to expect a counselor to "take over" and solve the problem for the client. This tendency is understandable, considering the patronizing fashion in which most services for Native Americans have been provided in the past. A system that prevents self-determination can lead to an attitude of resignation and passivity in Native Americans (Richardson, 1981). The counselor should consider the possible expectations of Native American clients in advance of the first session and be prepared to discuss the mutual responsibilities of the counselor and the client.

Non-Native American counselors should realize that their trustworthiness may be in question when seeing a Native American client. Many Native Americans feel that historically, White Americans have not been trustworthy in their dealings with Native Americans. The White counselor has no right to expect that Native American clients will automatically trust the counselor to have the client's interests at heart. Little empirical research has been conducted on this topic, but LaFromboise and Dixon (1981) did conduct one videotape session with 48 Native American high school students. The students rated the effectiveness of two counselors (one Native American and one non-Native American) in two role-played counseling interactions. Both counselors role-played as "trustworthy" and "non-trustworthy" therapists, using similar techniques. The students who watched the tape considered the sessions in which the counselors enacted the trustworthy role as positive, regardless of whether the counselor was Native American or non-Native American. The authors of this study concluded that the perceived trustworthiness of the counselor was more important than ethnic similarity between client and counselor.

It is understandable that, if all other factors are equal, Native American clients would prefer to see Native American counselors. However, given the small number of trained Native American therapists, the simple fact is that most Native Americans will have little choice but to see non-Native American

therapists. Richardson (1981) contended that Native American clients are likely to find non-Native American counselors effective if they behave in a trustworthy manner, and that this trust will be achieved over a period of time.

The counselor who often sees clients from a particular nearby tribe would benefit from learning about the history of the tribe, traditional beliefs and values, and current tribal organization. Studying both the problems and resources of the tribe could provide important information as background for seeing clients. The counselor should also investigate the tribe's family structure, age and gender roles, and characteristics of typical non-verbal behavior. Factors particularly relevant to counseling include beliefs about how problems should be resolved, the meaning attributed to illness or disability, and traditional healing practices. Information on the natural support systems, developmental stress points, and coping strategies can also be invaluable when serving clients who live on reservations or have traditional values (Trimble & LaFromboise, 1985). A substantial body of evidence has accrued suggesting that the traditional healing practices of many cultures can prove effective in dealing with diverse medical and behavioral problems of Native Americans (e.g., Frank, 1973; Jilek, 1974). In most tribes, traditional healers hold central and respected positions, and some authors have suggested that working collaboratively with them may be the most effective approach that conventional therapists can take in working with some groups for certain presenting problems (e.g., Jilek, 1974, Trimble, 1990).

THERAPEUTIC APPROACHES & STRATEGIES

Presently, due to a scarcity of controlled investigations, too little is known about Native Americans in therapy to identify treatments of choice or to make definite comparisons of the efficacy of therapeutic approaches. Renfrey (1992) suggests there is good reason to believe that cognitive-behavior therapists are well suited to providing culturally sensitive services to this population. The present time, action orientation of cognitive-behavior therapy and, to some extent, its directiveness seems to be congruent with the needs, values, and expectations of many Native Americans.

Although a parallel has been drawn between psychoanalytic therapy and some traditional Native American healing practices (Wallace, 1958), others have

argued that insight oriented therapies are inappropriate for more traditional Native Americans (Sue & Sue, 1977). The ingrained custom of many Native Americans to avoid self-revelation is related to the ineffectiveness of insight therapies. Accordingly, to ask such individuals to speak about private thoughts and feelings would be inappropriate. Similarly, French (1989) has asserted that ego and existential psychology have little relevance to many traditionals because their identities and self-concepts are bound to their tribal groups and to nature as a whole. As to what approach may be effective, Tafoya (1989) has asserted that treatments that are: (a) specific in their directives to alter behavior; (b) involve homework assignments; and (c) concentrate on altering present actions which then impact emotional states, rather than expecting a therapist to alter the emotional state and then achieve behavior change are more congruent with many traditional Native American healing customs.

Cultural differences in subtle verbal and non-verbal components of communication may serve to impede communication between Native Americans and the uninformed therapist. Several authors advise non-Native American counselors to avoid intense direct eye contact, since it can be considered disrespectful, and not to expect it from clients (Attneave, 1985; Matheson, 1986). Non-Native Americans are instructed to use a low tone of voice with Native American clients, to refrain from touching a client beyond a handshake (such as a pat on the back or a hug), and to use a soft handshake rather than a firm, aggressive one (Attneave, 1985). Furthermore, the expected "pause time" between alternating speakers may be longer for many Native Americans than for non-natives (as much as 4-5 seconds for some tribes versus about 1 second for native English speakers) (Tafoya, 1989). Long pauses during speech are common with some tribes, and silence itself may have communicative functions. This may cause an unenlightened therapist to interrupt the native client during speech and to give too little time to respond to queries. Further, many Native Americans expect to take a passive role in treatment and to have the therapist do most of the talking (Trimble, 1981). This may be in accordance with traditional healer roles, but it is incongruent with most conventional therapies.

Richardson (1981) recommends approaching each client as a unique individual, and take the lead from the client regarding nonverbal behavior. By

noting the client's behaviors, such as tone of voice, pace of speech, and degree of eye contact, and then matching them subtly, the development of rapport can be facilitated without offending the client.

As discussed earlier, many counselors find it helpful to go beyond the traditional office setting while serving Native American clients. Visiting a client's home on a reservation or in a rural area educates the counselor on the client's living situation and shows the client the counselor's level of interest and commitment. Attneave (1985) contended that going to the client's home also makes it much easier to involve the client's family. Even if the family is not directly involved in the client's problem they can provide crucial support and understanding for the client. In the informal context of the home setting clients are sometimes more receptive to advice, analogies, and appropriate self-disclosure on the part of the counselor.

In some cases it can be very helpful to collaborate with indigenous healers when seeing a reservation-based client. Lowrey (1983) found that counselors were able to obtain advice from traditional healers and to refer clients for a consultation with a healer. The therapist would obviously need the client's permission to seek help from traditional healers and the issue of confidentiality would have to be clarified. On some reservations policies have been established that allow traditional healers to serve clients and be reimbursed by the Indian Health Service as consultants on a contract basis. A client who has traditional values is likely to appreciate a non-Native American counselor's efforts to involve traditional healers.

Self-help and mutual support groups have been reported to be successful among groups of Native Americans both on and off reservations. Many tribes offer 12-step programs for substance abuse treatment through their local Indian Health Service office. In urban areas the local Native American center can provide similar services, and can at least offer ideas for referral of clients to self-help and other treatment groups (Pedigo, 1983).

CONCLUSION

Native Americans constitute a significant population that is growing and has great need for mental health and counseling services. All counselors should

have a basic understanding of the history and present status of Native Americans and should be able to serve members of this group. A familiarity with general Native American ideas about healing can provide a therapist with an understanding of what traditional Native Americans may expect from a counselor. Trimble & LaFromboise (1985) observed that in the process of establishing a trusting relationship with the client the counselor can learn specifics about the client's tribe and beliefs so that counseling interventions can mesh with the client's belief system, and therefore be more to likely to make sense to the client and lead to change.

Generally speaking, any skilled counselor who is sincere and meets the client as a person should be able to conduct therapeutic counseling with Native Americans. Following the client's lead in regard to nonverbal behavior will help to prevent misunderstandings and increase rapport. Then, a patient and informal exploration of the client's concerns will reveal whether counseling is the proper course of action. A fairly active and directive problem-solving approach can be effective with many clients, and other strategies can be employed as they seem appropriate with specific clients. When individual counseling seems too limiting or ineffective, the counselor has the option of including the client's family, visiting the client's home, and possibly involving a traditional healer from the client's tribe.

Christensen (1989) determined that much remains to be learned about the diagnosis and treatment of psychological problems among Native Americans. The endorsements of therapeutic approaches in the literature appear to be based upon clinical experience and not upon controlled outcome studies. Clearly, such studies are needed for definitive treatment comparisons and recommendations. Some models for training counselors in cross-cultural awareness have been developed, and these models should be compared systematically. In addition, more effort should be invested into recruiting Native American students into counselor education programs.

Counseling Native Americans provides an opportunity for the non-Native American therapist to develop new awareness for an important minority ethnic group, and new skills in cross-cultural counseling. In the process the counselor's world is enlarged and enriched and the client receives the kind of sensitive understanding and practical help that can lead to more effective living.

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